# DMHMRSAS SSDD APPLICATION REQUEST

**MAIL or FAX a signed copy of this form to:**

**Lakeisha Doman**
**Mental Health Community Support Services**
**P.O. Box 1797 – 10th Floor**
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**Telephone: (804) 786-5927**
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| Requestor Information | | | |
|---|---|---|---|
| **Work Location :** | | **Request Date:** | |
| **Employee Name: (Application User)**<br>**Print or type name on line 1 – Signature on line 2**<br>**Last 4 of SSN on line 3.** | | **Telephone Number: line 1**<br>**Email address: line 2** | |
| **1:** | | **1:** | |
| **2:** | **3:** | **2:** | |
| **Authorizing Official & Position:**<br>**Print or type name on line 1 – Signature on line 2** | | **Telephone Number: line 1**<br>**Email address: line 2** | |
| **1:** | | **1:** | |
| **2:** | | **2:** | |

**By signing this form the Authorizing Official and the Employee (Application User) acknowledge that any change in the Employee's status which would no longer require the Employee to access this confidential data must be reported by the Authorizing official to Lakeisha Doman. This is critical to ensure the protection of the data. Any attempt by the Employee to access this data after a status change can result in legal action being taken against them in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule.**